MEYER CLINIC

MEDICAL HISTORY FORM

For best functionlity, save PDF to your computer as: MEDICAL-HISTORY-FORM-*LAST NAME-FIRST NAME*.PDF
Fill out form locally, not with a internet browser PDF viewer.

FULL NAME: **DATE:** / /

HEIGHT: **FT** **IN** **WEIGHT:** **LBS**

AGE: **GENDER:**

DOCTOR: **OFFICE:**

SIGNATURE:

ANY ADDITIONAL INFORMATION YOU WOULD LIKE TO SHARE WITH THE DOCTOR:

HOW TO SUBMIT THIS FORM

Please save as: "MEDICAL-HISTORY-FORM-*LAST NAME-FIRST NAME*.PDF"
Example: "MEDICAL-HISTORY-FORM-BUKZIN-JAY.PDF"

Option 1) Save completed form and click "SUBMIT" on the first or the last page.

Option 2) Save completed form and email file to INFO@MEYERCLINIC.COM.

Option 3) Print out the form and bring it with you to your next appointment.
***You can print an empty form and fill it out by hand or fill it out on the computer then save and print it when you are done!

If there are any questions or concerns about the form, do not hesitate to contact us:

Arlington: (703) 483-9591 Gainesville: (703) 753-7933

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PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY:

1. Are you in good health? If no or not sure, please explain:
   YES ○ NOT SURE ○ NO ○ N/A ○

2. Have there been any changes in your general health in the past year?
   YES ○ NOT SURE ○ NO ○ N/A ○

3. Are you under the care of a physician? If yes, please provide their name, specialty and telephone number.
   YES ○ NOT SURE ○ NO ○ N/A ○

4. Have you had any illness, operation or been hospitalized in the past five years? If yes, please explain:
   YES ○ NOT SURE ○ NO ○ N/A ○

5. Do you have unhealed injuries or inflamed areas in or around your mouth, and/or growths or sore spots in your mouth? If yes, where:
   YES ○ NOT SURE ○ NO ○ N/A ○

6. Do you have a prosthetic joint? If yes, describe where:
   YES ○ NOT SURE ○ NO ○ N/A ○

OF THE FOLLOWING, HAVE YOU HAD OR CURRENTLY HAVE:

7. Rheumatic fever: YES ○ NO ○ NOT SURE ○ N/A ○
8. Damaged heart valve/mitral valve prolapse YES ○ NO ○ NOT SURE ○ N/A ○
9. Heart murmur YES ○ NO ○ NOT SURE ○ N/A ○
10. High blood pressure YES ○ NO ○ NOT SURE ○ N/A ○
11. Low blood pressure YES ○ NO ○ NOT SURE ○ N/A ○
12. Chest pain or angina YES ○ NO ○ NOT SURE ○ N/A ○

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13.	Heart attack	YES ○	NO ○	NOT SURE ○	N/A ○
14.	Irregular heartbeat	YES ○	NO ○	NOT SURE ○	N/A ○
15.	Cardiac pacemaker	YES ○	NO ○	NOT SURE ○	N/A ○
16.	Heart surgery	YES ○	NO ○	NOT SURE ○	N/A ○
17.	Bronchitis, chronic cough	YES ○	NO ○	NOT SURE ○	N/A ○
18.	Asthma	YES ○	NO ○	NOT SURE ○	N/A ○
19.	Hayfever or sinus problems	YES ○	NO ○	NOT SURE ○	N/A ○
20.	Tuberculosis	YES ○	NO ○	NOT SURE ○	N/A ○
21.	Emphysema	YES ○	NO ○	NOT SURE ○	N/A ○
22.	Difficulty breathing/other lung troubles	YES ○	NO ○	NOT SURE ○	N/A ○
23.	Blood transfusions	YES ○	NO ○	NOT SURE ○	N/A ○
24.	Blood disorder (e.g. anemia)	YES ○	NO ○	NOT SURE ○	N/A ○
25.	Abnormal bleeding	YES ○	NO ○	NOT SURE ○	N/A ○
26.	Jaundice, hepatitis, or liver disease	YES ○	NO ○	NOT SURE ○	N/A ○
27.	Infectious mononucleosis	YES ○	NO ○	NOT SURE ○	N/A ○
28.	Gallbladder trouble	YES ○	NO ○	NOT SURE ○	N/A ○
29.	Fainting spells	YES ○	NO ○	NOT SURE ○	N/A ○
30.	Convulsions or epilesy	YES ○	NO ○	NOT SURE ○	N/A ○
31.	Stroke(s)	YES ○	NO ○	NOT SURE ○	N/A ○
32.	Thyroid trouble	YES ○	NO ○	NOT SURE ○	N/A ○
33.	Diabetes	YES ○	NO ○	NOT SURE ○	N/A ○
34.	Low blood sugar	YES ○	NO ○	NOT SURE ○	N/A ○
35.	Kidney trouble	YES ○	NO ○	NOT SURE ○	N/A ○

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36.	Swollen ankles, arthitis, or joint disease	YES ◯	NO ◯	NOT SURE ◯	N/A ◯
37.	Stomach ulcers	YES ◯	NO ◯	NOT SURE ◯	N/A ◯
38.	Contagious diseases	YES ◯	NO ◯	NOT SURE ◯	N/A ◯
39.	Sexualy transmitted diseases	YES ◯	NO ◯	NOT SURE ◯	N/A ◯
40.	HIV/AIDS	YES ◯	NO ◯	NOT SURE ◯	N/A ◯
41.	Problems of the immune systems	YES ◯	NO ◯	NOT SURE ◯	N/A ◯
42.	Tumors or growths	YES ◯	NO ◯	NOT SURE ◯	N/A ◯
43.	Mental health problems	YES ◯	NO ◯	NOT SURE ◯	N/A ◯
44.	Removable dental device	YES ◯	NO ◯	NOT SURE ◯	N/A ◯
45.	Eye disease (e.g. glaucoma)	YES ◯	NO ◯	NOT SURE ◯	N/A ◯
46.	Radiation treatment/chemotherapy	YES ◯	NO ◯	NOT SURE ◯	N/A ◯
47.	Chronic fatigue/night sweats	YES ◯	NO ◯	NOT SURE ◯	N/A ◯
48.	Pain and clicking of jaws when eating	YES ◯	NO ◯	NOT SURE ◯	N/A ◯
49.	Malignant hyperthermia	YES ◯	NO ◯	NOT SURE ◯	N/A ◯
ARE YOU...?					
50.	On a special diet	YES ◯	NO ◯	NOT SURE ◯	N/A ◯
51.	On dialysis	YES ◯	NO ◯	NOT SURE ◯	N/A ◯
DO YOU...?					
52.	Bruise easily	YES ◯	NO ◯	NOT SURE ◯	N/A ◯
53.	Smoke	YES ◯	NO ◯	NOT SURE ◯	N/A ◯
54.	Drink alcoholic beverages	YES ◯	NO ◯	NOT SURE ◯	N/A ◯
55.	Use habit-forming drugs	YES ◯	NO ◯	NOT SURE ◯	N/A ◯
56.	Wear contact lenses	YES ◯	NO ◯	NOT SURE ◯	N/A ◯

57. Is there any condition concerning your health or family's anesthetic history that the doctor should know about? If yes, please explain:

YES ○ NOT SURE ○
NO ○ N/A ○

ARE YOU ON ANY OF THE FOLLOWING MEDICATIONS...

58. Anticoagulants: YES ○ NO ○ NOT SURE ○ N/A ○

59. Cortisone: YES ○ NO ○ NOT SURE ○ N/A ○

60. Osteoporosis/osteopenia medications: YES ○ NO ○ NOT SURE ○ N/A ○

61. Any other medications: YES ○ NO ○ NOT SURE ○ N/A ○

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

62. Penicillin YES ○ NO ○ NOT SURE ○ N/A ○

63. Sulfa drugs YES ○ NO ○ NOT SURE ○ N/A ○

64. Any other antibiotics: YES ○ NO ○ NOT SURE ○ N/A ○

65. Sodium Pentothal, Valium or other tranquilizers: YES ○ NO ○ NOT SURE ○ N/A ○

66. Aspirin YES ○ NO ○ NOT SURE ○ N/A ○

67. Codeine or other narcotics YES ○ NO ○ NOT SURE ○ N/A ○

68. Latex YES ○ NO ○ NOT SURE ○ N/A ○

WOMEN

69. Are you taking birth control pills? YES ○ NO ○ NOT SURE ○ N/A ○

70. Are you nursing? YES ○ NO ○ NOT SURE ○ N/A ○

71. Are you pregnant? Due date: / / YES ○ NO ○ NOT SURE ○ N/A ○

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